Illinois Department of Public Aid

no. H200-02-3

ILLINOIS MEDICAL ASSISTANCE PROGRAM
PROVIDER BULLETIN

August 14, 2002

TO: Enrolled Hospitals – Chief Executive Officers, Chief Financial Officers, Patient Accounts Managers and Utilization Review Departments

RE: Revised Adult and Child/Adolescent Psychiatric Review Criteria, Psychiatric Generic Quality Screen Guidelines and Detoxification Review Criteria

Effective September 16, 2002, the Department's Peer Review Organization (PRO), HealthSystems of Illinois (HSI), will implement the revised Adult and Child/Adolescent Psychiatric Review Criteria, Psychiatric Generic Quality Screen Guidelines and Detoxification Review Criteria.

Review Process

Initial review is completed by a review nurse (Utilization Review Coordinator) who utilizes screening criteria to determine medical necessity of the inpatient stay. The Utilization Review Coordinator (URC) may approve services meeting the criteria as medically necessary or refer the case to a Physician Peer Reviewer (PPR) for determination of medical necessity. The URC may also refer cases with potential coding errors or quality issues. The Physician Peer Review is conducted by practicing physicians matched to the specialty of the care being reviewed. The PPR bases his/her decision on medical judgement. The PPR may issue a denial when the admission or stay was determined not medically necessary. The hospital or physician then has the opportunity to request an expedited reconsideration for admission/concurrent review or a standard reconsideration for cases discharged from the hospital. The expedited reconsideration occurs within one day after HSI's receipt of the request from the physician or hospital. The standard reconsideration for cases discharged occurs within 60 days of the date of the denial notice from HSI. The date of the denial notice is considered as day one.

Copies of all criteria are attached. This bulletin and the criteria may also be obtained from the Department's website at **http://www.state.il.us/dpa/provider_release_bulletins.htm**

Hospitals will be sent an informational notice with attachments identifying diagnosis and DRG codes subject to review. This notice and attachments will also available on the Department's website as noted above.

Instructions for Updating the Handbook For Hospitals:
Replace pages 8 through 26 in Appendix H-6 of the Hospital Handbook with the attached pages 8 through 26b dated September 16, 2002.

CRITERIA FOR CHILD/ADOLESCENT PSYCHIATRIC INPATIENT TREATMENT

JUSTIFICATION FOR ADMISSION TO INPATIENT SETTING FOR TREATMENT

Inpatient psychiatric hospital services for the treatment of a child or adolescent under the age of twenty-one (21) may only be certified as medically necessary for "active treatment" which can reasonably be expected to improve the patient's condition.

GENERAL GUIDELINES FOR ACUTE HOSPITAL SERVICES

For services to be designated as "active treatment" they must include these criteria:

1. The patient's condition affirms the need for specialized resources and/or a structured environment in a selected facility for diagnosis, evaluation, or treatment.

2. The patient's response to treatment affirms that a less intensive or restrictive psychiatric treatment program would not be adequate to provide safety for the patient or others or to improve the patient's functioning.

3. An individualized treatment program geared toward the development and therapeutic needs of the patient and family.

4. Care is supervised and evaluated by a licensed physician who has completed an accredited psychiatric residency (i.e., Accreditation Council for Graduate Medical Education or Accreditation of Colleges of Osteopathic Medicine).

It is expected that the resources and techniques associated with this level of care will lead to successful discharge into the community or transfer to a less intensive or restrictive treatment program.

SEVERITY OF ILLNESS (SI)

(**One** of the following must be met or refer to a physician reviewer.)

1. Acute danger to self, others, or property.

2. Acute disabling signs and symptoms as a response to bio-psychosocial stress, such as impaired reality testing, disordered or bizarre behavior, organic brain psychosis, depression, anxiety, conversion, dissociation, depersonalization, somatization, severe avoidance or social withdrawal, compulsion(s), disordered sleep, over/under activity, and/or eating disorder.

3. Medical necessity for diagnostic procedure only available in the acute hospital setting.

4. Psychiatric disorder significantly complicating evaluation and treatment of another condition.

5. Severe impairment of interpersonal, familial, and/or occupational-academic functioning non-responsive to less restrictive treatment.

INTENSITY OF SERVICE (IS)

(At minimum, **two** criteria must be met or refer to a physician reviewer.)

1. Complex treatment necessitated by co-existing conditions requiring concurrent treatment (e.g., an insulin-dependent diabetic who is neglecting diabetic care due to major depression, chronic respiratory or cardiovascular insufficiency, etc.).

2. A need for a controlled environment to protect self and others (e.g., suicide precautions, instituted isolation, etc.).

3. Special treatment modalities which may only be safely provided for the patient in the hospital due to need for special environment, equipment, or ancillary services (e.g., planned and controlled psychotropic drug management).

4. For patients with a high potential for near-term readmission [within 30 days] (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's capacity to maintain the treatment plan, or identified need for specialized outpatient milieu), the medical record must reflect efforts taken to address these issues to prevent further readmissions.

DISCHARGE SCREENS

(**One** of the following must be met or refer to a physician reviewer.)

1. Documentation that patient no longer poses a risk of harm to self or others.

2. Documentation by psychiatrist of lessening or resolution of signs and symptoms sufficient to allow for functioning outside of the acute setting.

3. Documentation is not present indicating evidence of reasonable expectation of significant psychiatric improvement with continued inpatient treatment.

4. Documentation is not present of initiation of initial therapeutic plan by the attending physician within 24 hours of admission and multidisciplinary treatment plan if the patient remains in the hospital five days or longer.

5. Documentation is not present of weekly revision to multidisciplinary treatment plan.

6. Documentation is not present regarding purpose and subsequent evaluation of out-of-hospital passes.

DOCUMENTATION GUIDELINES

The following components have been defined to assist the admitting psychiatrist and ancillary staff in providing the necessary documentation indicative of active psychiatric care or intensity of service:

- Within 24 hours of admission, a psychiatric assessment (including the reason for admission, mental status examination, determination of diagnosis and identification of behavior/symptoms that need clinical intervention, and initial therapeutic plan based on identified needs) must be documented in the medical record by an attending physician. Other medical history and physical examination must also be completed within 24 hours of admission.

- If a patient remains in the hospital ≥5 days, a multidisciplinary treatment plan should be documented in the medical record by the attending physician, with input from other members of the treatment team, on the 5th day of hospitalization. The multidisciplinary treatment plan should be implemented on the 7th day of hospitalization and include:

  - Clinical activities designed to enhance the patient's functioning sufficient for the patient to be transferred to a less restrictive care environment with a decreased likelihood of readmission.

  - Estimated timeframes to achieve goals including a re-evaluation if goals are not met, and changes are needed; a new plan formulated if necessary.

- If a multidisciplinary treatment plan is warranted, multidisciplinary treatment plan/progress must be documented **at least weekly.**

- Regular progress notes should be completed by non-nursing, non-physician clinicians **at least weekly.**

- Physician involvement consistent with the **acuity/complexity** of the case. Physician involvement requires documentation in the form of a progress note. Attending physician's orders (written or verbal) or signature on the treatment plan are not substitutions for adequate physician involvement. The **usual and customary standard is 5-6 progress notes per week.** In order to reflect adequate physician involvement, resident physician documentation must reflect that the patient was seen, and clinical interventions discussed with the attending physician.

- Developmentally appropriate skilled psychiatric nursing must be reflected in the medical record daily and must contain an appropriate sample of clinical nursing observations and interchanges between the patient and nursing staff. In addition, an assessment of the patient for therapeutic and side effects of medications should be documented.

- Assessment of family or surrogate (foster) family should occur within **five** days of admission. Involvement with community agencies should also occur within **five** days. Special difficulties with family or agency should be documented.

- Developmentally/diagnostically appropriate educational program should be implemented within **five** days of admission for school-aged children.

- If a patient remains in the hospital $\geq$ 21 days, initiation of an appropriate educational and/or vocational evaluation, which is developmentally/diagnostically appropriate, should be documented in the medical record no later than the 21st day of hospitalization.

- Age-appropriate daily recreational therapy activities.

- Discharge planning should commence upon admission, must be documented weekly in the medical record, and should be part of the team's weekly evaluation of achievable goals. In addition, appropriate and timely followup arrangements should be documented and include a scheduled followup appointment. An explanation at the time of discharge should be documented if an appointment cannot be arranged. Patient refusal of suggested followup arrangements should be documented.

- Treatment may necessitate discontinuance of therapy for a period of time, or a period of observation as preparation for therapy, or as a followup to therapy, while maintenance or protective services are provided. If these are essential to the overall plan, they are part of active treatment.

- Treatment may necessitate obtaining and waiting for legal permission to treat patient without consent and is considered as active treatment.

- Out-of-hospital passes are allowed if there is documentation explaining purpose and subsequent evaluation of the pass. Overnight passes off premises are not reimbursed by the Medical Assistance Program.

- For patients with a high potential for near-term readmission [within 30 days] (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's capacity to maintain the treatment plan, or identified need for specialized outpatient milieu), the medical record must reflect efforts taken to address these issues to prevent further readmissions.

CHILD/ADOLESCENT PSYCHIATRIC REVIEW WORKSHEET

Apply Peel-Off Patient Label

SI - ONE OF THE FOLLOWING MUST BE MET OR REFER TO PR:

		Y	OV	N	COMMENT
1.	Acute danger to self, other, or property	☐	☐	☐	_____
2.	Acute disabling signs and symptoms as a response to bio-psychosocial stress	☐	☐	☐	_____
3.	Medical necessity for diagnostic procedure available only in the acute hospital setting	☐	☐	☐	_____
4.	Psychiatric disorder significantly complicating evaluation and treatment of another condition	☐	☐	☐	_____
5.	Severe impairment of interpersonal, familial, and/or occupational-academic functioning non-responsive to less restrictive treatment	☐	☐	☐	_____

ALL DOCUMENTATION GUIDELINES MUST BE MET OR REFER TO PR:
(Supplement to IS)

1.	Written psychiatric assessment (including reason for admission, mental status examination, determination of diagnosis and identification of behaviors/symptoms that need clinical intervention, and initial therapeutic plan based on identified needs) within 24 hours. Other medical history and physical examination also within 24 hours.	☐	☐	☐	_____
2.	If a patient remains in the hospital $\geq$5 days, a developmentally appropriate multidisciplinary treatment plan should be documented on the 5th day of hospitalization. The plan should be implemented on the 7th day of hospitalization and include:	☐	☐	☐	_____
	A. Clinical activities designed to enhance the patient's functioning sufficient for the patient to be transferred to a less restrictive care environment with a decreased likelihood of readmission.	☐	☐	☐	_____
	B. Estimated time frames to achieve goals including a re-evaluation if goals are not met, and changes are needed; a new plan formulated if necessary.	☐	☐	☐	_____
3.	Multidisciplinary treatment plan/progress must be documented at least weekly.	☐	☐	☐	_____

		Y	OV	N	COMMENT
4.	Regular progress notes should be completed by non-nursing, non-physician clinicians at least weekly.	☐	☐	☐	_____
5.	Physician involvement consistent with the **acuity/complexity** of the case. Physician involvement requires documentation in the form of a progress note. Attending physician's orders (written or verbal) or signature on the treatment plan are not substitutions for adequate physician involvement. **The usual and customary standard is 5-6 progress notes per week.** In order to reflect adequate physician involvement, resident physician documentation must verify that the patient was seen and clinical intervention discussed with the attending physician.	☐	☐	☐	_____
6.	Developmentally appropriate skilled psychiatric nursing must be reflected in medical record.	☐	☐	☐	_____
7.	Assessment of the family or surrogate family within 5 days.	☐	☐	☐	_____
8.	Engagement with appropriate community agencies within 5 days.	☐	☐	☐	_____
9.	Developmentally/diagnostically appropriate educational program within 5 days for school-aged children.	☐	☐	☐	_____
10.	If the patient remains in the hospital $\geq$21 days, an appropriate educational or vocational evaluation which is developmentally/ diagnostically appropriate should be documented in the medical record no later than the 21st day of hospitalization.	☐	☐	☐	_____
11.	Age-appropriate daily recreational therapy activities.	☐	☐	☐	_____
12.	Discharge planning should commence upon admission.	☐	☐	☐	_____
13.	Documentation of appropriate and timely followup arrangements.	☐	☐	☐	_____
14.	Out-of-hospital passes must be documented and include purpose and subsequent evaluation of pass.	☐	☐	☐	_____
15.	For patients with a high potential for near-term readmission [within 30 days] (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's capacity to maintain the treatment plan, or identified need for specialized outpatient milieu), the medical record must reflect efforts taken to address these issues to prevent further readmissions.	☐	☐	☐	_____
16.	Discharge screen met.	☐	☐	☐	_____

CRITERIA FOR ADULT PSYCHIATRIC INPATIENT TREATMENT

JUSTIFICATION FOR ADMISSION TO INPATIENT SETTING FOR TREATMENT

Inpatient psychiatric hospital services for the treatment of an adult, twenty-one (21) years of age and older, may only be certified as medically necessary for "active treatment" which can reasonably be expected to improve the patient's condition.

GENERAL GUIDELINES FOR ACUTE HOSPITAL SERVICES

For services to be designated as "active treatment" they must include these criteria:

1. The patient's condition affirms the need for required specialized resources and/or a structured environment in a selected facility for diagnosis, evaluation, or treatment.

2. The patient's response to treatment reflects that a less intensive or less restrictive psychiatric treatment program would not be adequate to provide safety for the patient or others or to improve the patient's functioning.

3. An individualized treatment program geared toward the development and therapeutic needs of the patient and, where appropriate, family.

4. Care is supervised and evaluated by a licensed physician who has completed an accredited psychiatric residency i.e., Accreditation Council for Graduate Medical Education or Accreditation of Colleges of Osteopathic Medicine.

It is expected that the resources and techniques associated with this level of care will lead to successful discharge into the community or transfer to a less intensive or restrictive treatment program.

SEVERITY OF ILLNESS (SI)

(**One** of the following must be met or refer to a physician reviewer.)

1. Documentation indicates a need for continuous skilled psychiatric observation, planned psychotherapeutic program, planned and controlled psychotropic drug management, and/or electroconvulsive therapy.

2. Inability to care for self due to an interaction of mental and other physical disorders creating incapacitating symptoms and/or behaviors.

3. Significant suicide risk. The following helps to define "significant risk":

   - hopelessness and/or worthlessness; or,
   - history of unpredictable behavior, agitation, impulsivity, or poor judgment; or,
   - patient history of previous suicide attempts; or,
   - persistent insomnia with deterioration in mood or cognition; or,
   - patient history of noncompliance with treatment recommendations in the past; or,
   - family history of suicide attempts or completed suicide; or,
   - patient history of abusing drugs that could lead to impulsiveness or poor judgment; or,
   - significant changes in mood or behavior; or,
   - patient history of recent loss (e.g., job, relationship, family member, etc.); or,
   - preoccupation with suicidal thoughts; or,
   - whether or not there is a plan; or,
   - presence of a plan with reasonable expectation for completion.

4. History of assaultive and/or self-mutilative behavior or reported evidence of danger to self and/or others.

5. Homicidal ideation accompanied by psychiatric disorder.

6. Impaired reality testing accompanied by disordered behavior (e.g., bizarre, delusional, illogical thinking, hallucinations, manic behavior, etc.).

7. Failure to respond to **active** outpatient therapy.

INTENSITY OF SERVICE (IS)

(At a minimum, **two** criteria must be met or refer to a physician reviewer.)

1. Complex treatment necessitated by co-existing conditions requiring concurrent treatment (e.g., an insulin-dependent diabetic who is neglecting diabetic care due to major depression, chronic respiratory or cardiovascular insufficiency, etc.).

2. A need for a controlled environment to protect self and others (e.g., suicide precautions, instituted isolation, etc.)

3. Special treatment modalities available only in the hospital due to need for special environment, equipment, or ancillary services (e.g., planned and controlled psychotropic drug management). The need for inpatient electroconvulsive therapy will be evaluated on an individual basis and be based upon medical necessity.

4. For patients with a high potential for near-term readmission [within 30 days] (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's capacity to maintain the treatment plan, or identified need for specialized outpatient milieu), the medical record must reflect efforts taken to address these issues to prevent further readmissions.

DISCHARGE SCREENS

(**One** of the following must be met or refer to a physician reviewer.)

1. Documentation that patient no longer poses a risk of harm to self or others.

2. Documentation by psychiatrist of lessening or resolution of signs and symptoms sufficient to allow for functioning outside of the acute setting.

3. Documentation is not present indicating evidence of reasonable expectation of significant psychiatric improvement with continued inpatient treatment.

4. Documentation is not present of initiation of initial therapeutic plan by the attending physician within 24 hours of admission and multidisciplinary treatment plan if the patient remains in the hospital five days or longer.

5. Documentation is not present of weekly revision to multidisciplinary treatment plan.

6. Documentation is not present regarding purpose and subsequent evaluation of out-of-hospital passes.

DOCUMENTATION GUIDELINES

The following components have been defined to assist the admitting psychiatrist and ancillary staff in providing the necessary documentation indicative of active psychiatric care or intensity of service:

- Within 24 hours of admission, a psychiatric assessment (including the reason for admission, mental status examination, determination of diagnosis and identification of behavior/symptoms that need clinical intervention, and initial therapeutic plan based on identified needs) must be documented in the medical record by an attending physician. Other medical history and physical examination must also be completed within 24 hours of admission.

- If a patient remains in the hospital $\geq$ 5 days, a multidisciplinary treatment plan should be documented in the medical record by the attending physician, with input from other members of the treatment team on the 5th day of hospitalization. The multidisciplinary treatment plan should be implemented on the 7th day of hospitalization and include:

  - Clinical activities designed to enhance the patient's functioning sufficient for the patient to be transferred to a less restrictive care environment with a decreased likelihood of readmission.

  - Estimated timeframes to achieve goals including a re-evaluation if goals are not met, and changes needed; a new plan formulated if necessary.

- If a multidisciplinary treatment plan is warranted, multidisciplinary treatment plan/progress must be documented **at least weekly.**

- Regular progress notes should be completed by non-nursing, non-physician clinicians **at least weekly.**

- Physician involvement consistent with the **acuity/complexity** of the case. Physician involvement requires documentation in the form of a progress note. Attending physician's orders (written or verbal) or signature on the treatment plan are not substitutions for adequate physician involvement. The **usual and customary standard is 5-6 progress notes per week.** In order to reflect adequate attending physician involvement, resident physician documentation must reflect the patient was seen, and clinical interventions discussed with the attending physician.

- Skilled psychiatric nursing must be reflected in the medical record **daily** and must contain an appropriate sample of clinical nursing observations and interchanges between the patient and nursing staff. In addition, an assessment of the patient for therapeutic and side effects of medications should be documented.

- Discharge planning needs/efforts must be documented **weekly** in the medical record and should be part of the team's weekly evaluation of achievable goals. In addition, appropriate and timely followup arrangements should be documented and include a scheduled followup appointment. An explanation at the time of discharge should be documented if an appointment cannot be arranged. Patient refusal of suggested followup arrangements should be documented.

- Treatment may necessitate discontinuance of therapy for a period of time, or a period of observation as preparation for therapy, or as a followup to therapy, while maintenance or protective services are provided. If these are essential to the overall plan, they are part of active treatment.

- Out-of-hospital passes are allowed if there is documentation explaining purpose and subsequent evaluation of the pass. (Overnight passes off premises are not reimbursed by the Medical Assistance Program.)

- For patients with a high potential for near-term readmission [within 30 days] (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's capacity to maintain the treatment plan, or identified need for specialized outpatient milieu), the medical record must reflect efforts taken to address these issues to prevent further readmissions.

(RESERVED)

ADULT PSYCHIATRIC REVIEW WORKSHEET

Apply Peel-Off Patient Label

SI - ONE OF THE FOLLOWING MUST BE MET OR REFER TO PR:

		Y	OV	N	COMMENT
1.	Documented need for skilled psychiatric care	☐	☐	☐	_____
2.	Inability to care for self	☐	☐	☐	_____
3.	Significant suicide risk	☐	☐	☐	_____
4.	History of assaultive and/or self-mutilative behavior	☐	☐	☐	_____
5.	Homicidal ideation accompanied by psychiatric disorder	☐	☐	☐	_____
6.	Impaired reality testing accompanied by disordered behavior (e.g., bizarre, delusion, illogical thinking, hallucinations, manic behavior, etc.)	☐	☐	☐	_____
7.	Failure to respond to active outpatient therapy	☐	☐	☐	_____

ALL DOCUMENTATION GUIDELINES MUST BE MET OR REFER TO PR:
(Supplement to IS)

1.	Written psychiatric assessment (including reason for admission, mental status examination, determination of diagnosis and identification of behaviors/symptoms that need clinical intervention, and initial therapeutic plan based on identified needs) within 24 hours. Other medical history and physical examination also within 24 hours.	☐	☐	☐	_____
2.	If a patient remains in the hospital $\geq$5 days, a multi-disciplinary treatment plan should be documented on the 5th day of hospitalization. The plan should be implemented on the 7th day of hospitalization and include:	☐	☐	☐	_____
	1. Clinical activities designed to enhance the patient's functioning sufficient for the patient to be transferred to a less restrictive care environment with decreased likelihood of readmission.	☐	☐	☐	_____
	2. Estimated time frames to achieve goals including a re-evaluation if goals are not met, and changes are needed; a new plan formulated if necessary.	☐	☐	☐	_____

	Y	OV	N	COMMENT
3. Multidisciplinary treatment plan/progress must be documented at least weekly.	☐	☐	☐	_____
4. Regular progress notes should be completed by non-nursing, non-physician clinicians at least weekly.	☐	☐	☐	_____
5. Physician involvement consistent with the **acuity/complexity** of the case. Physician involvement requires documentation in the form of a progress note. Attending physician's orders (written or verbal) or signature on the treatment plan are not substitutions for adequate physician involvement. **The usual and customary standard is 5-6 progress notes per week.** In order to reflect adequate physician involvement, resident physician documentation must verify that the patient was seen, and clinical intervention discussed, with the attending physician.	☐	☐	☐	_____
6. Skilled psychiatric nursing must be reflected in medical record.	☐	☐	☐	_____
7. Documentation of discharge planning weekly.	☐	☐	☐	_____
8. Documentation of appropriate and timely follow up arrangements.	☐	☐	☐	_____
9. Out-of-hospital passes must be documented and include purpose and subsequent evaluation of pass.	☐	☐	☐	_____
10. For patients with a high potential for near-term readmission [within 30 days] (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's capacity to maintain the treatment plan, or identified need for specialized outpatient milieu), the medical record must reflect efforts taken to address these issues to prevent further readmissions.	☐	☐	☐	_____
11. Discharge screen met.	☐	☐	☐	_____

PSYCHIATRIC
GENERIC QUALITY SCREEN GUIDELINES

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTE
1. Inadequate psychiatric assessment	None	A screen failure is indicated if a psychiatric assessment was not completed within 24 hours of admission by an attending physician and did not include/address the following: a. Reason for admission. b. Mental status exam. c. Determination of diagnosis and identification of behavior/symptoms that need clinical intervention. d. Initial therapeutic plan based on identified clinical needs. Physician orders must be obtained at the time of admission. In addition, a screen failure is indicated if other medical history and physical examination was not completed within 24 hours of admission.
2. Inadequate treatment planning	None	Each patient's treatment plan must be based on an inventory of their strengths and weaknesses and should be discussed with the patient. A screen failure is indicated if treatment planning did not contain the following: a. An initial therapeutic plan based on identified clinical needs by the attending physician within 24 hours of admission. b. If a patient remains in the hospital $\geq$5 days, a multi-disciplinary treatment plan must be documented in the medical record by the attending physician, with input from other members of the treatment team, on the 5th day of hospitalization. The plan should be implemented on the 7th day of hospitalization and include: 1. Clinical activities designed to enhance the patient's functioning sufficient for the patient to be transferred to a less restrictive care environment with a decreased likelihood of readmission. 2. Estimated timeframes to achieve goals including a re-evaluation if goals are not met, and changes are needed; a new plan formulated if necessary. c. Documentation of at least weekly revisions to multi-disciplinary treatment plan.

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTE
2. Inadequate treatment planning (continued)		In addition, a screen failure is indicated if the following are not completed for the child/adolescent population: a. Assessment of family or surrogate family within five days. b. Engagement with appropriate community agencies within five days. c. Appropriate educational program within five days for school aged children. d. If a patient remains in the hospital ≥21 days, an appropriate educational or vocational evaluation should be documented in the medical record no later than the 21st day of hospitalization.
3. Lack of ongoing monitoring and evaluation of patient status to identify conditions or changes in conditions which could potentially lead to patient harm and/or deterioration.	None	A screen failure is indicated if ongoing monitoring and evaluation of patient status did not include: a. Regular progress notes completed by non-nursing, non-physician clinicians at least weekly. b. Physician involvement consistent with the **acuity/complexity of case**. Physician involvement requires documentation in the form of a progress note. Attending physician's orders (written or verbal) or signature on the treatment plan are not substitutions for adequate physician involvement. The usual and customary standard is 5-6 progress notes per week. In order to reflect adequate physician involvement, resident physician documentation must reflect that the patient was seen, and clinical interventions discussed with the attending physician. c. Documentation of daily skilled psychiatric nursing containing an appropriate sample of clinical nursing observations and interchanges between the patient and nursing staff. In addition, an assessment of the patient for main effects and side effects of medications should be documented. d. Documentation explaining purpose and subsequent evaluation of out-of-hospital pass(es). e. Evaluation and follow-up on abnormal laboratory tests and/or studies. f. Services/therapies consistent with patient signs/symptoms. g. Age-appropriate daily recreational therapy activities for the child/adolescent population.
4. Medications a. Inadequate/inappropriate use	None	A screen failure is indicated when medications are being utilized in the following ways: 1. Chemical restraint (as defined by DHS and CMS). 2. Sedative/hypnotic use for greater than seven consecutive days or in the face of significant side effects. 3. Prescription PRN use for greater than five consecutive days. 4. Changes in drug regime more than two times in seven days, not including dosage adjustments. 5. Concurrent use of more than two drugs of the same drug class. 6. Two new medications started simultaneously in patients under the age of 18.

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTE
4. Medications (continued) b. Failure to monitor use		A screen failure is indicated if monitoring of medication use is not being performed in the following way: 1. The following needs to be addressed promptly: confusion, high fever, serious alteration in behavior, and motor manifestations (e.g., tics, rigidity). 2. Medications adjusted as required by drug levels, side effects, or symptoms. 3. Adequate pre-medication work-up (Reference: National Institute of Mental Health's *Psychotropic Drugs - Approaches to Psychopharmacologic Drug Use).* 4. Serum drug levels performed as needed (Reference: National Institute of Mental Health's *Psychotropic Drugs - Approaches to Psychopharmacologic Drug Use).* 5. Overdosing/underdosing avoided as a result of appropriate monitoring for checking and hoarding of medications. 6. PRN medication administered with documentation of effects.
c. Major adverse drug reactions or medication error with a serious potential for harm, or results in special measures to correct.	None	A screen failure is indicated if one of the following events occurs: 1. A drug is ordered that is inconsistent with diagnostic studies or for which there is a documented known allergy or adverse interaction. 2. Medication is administered to a patient that deviates from the physician's orders, (e.g. omission, wrong dose).
5. Harm/trauma suffered in the hospital a. Attempted suicide and/or self-inflicted injury b. Fall c. Seizure d. Loss of consciousness e. Other serious or potentially serious complications or injuries		A screen failure is indicated if one of the following events occurs: • Diagnostic and subsequent treatment decisions were based on inappropriate or unavailable test utilization and results. • Diagnostic studies not performed as indicated or needed. • Other measures for side effects, such as AIMS exam (for individuals on neuroleptics), not performed as indicated or needed. • Inadequate monitoring, supervision, or intervention by staff.

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTE
6. Restraints (including physical and mechanical)	None	Use of a physical or mechanical device to involuntarily restrain movement of the whole or a portion of a patient's body as a means of controlling a patient's physical activities to protect the patient or others from injury. Restraint is differentiated from mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures that are considered a regular and usual part of such procedures (e.g., body restraint during surgery, arm restraint during intravenous administration, restraints to prevent a non-ambulatory or less than fully conscious patient from falling out of bed or out of a wheelchair, temporary physical restraint prior to administration of ECT, etc.). Restraint does not include the use of devices such as bed rails, table top chairs, protective nets, or helmets when used as protective, or the use of orthopedic appliances, braces, wheelchairs, and other appliances or devices used for postural support of the patient or to assist the patient in obtaining and maintaining normal bodily function.
a. Inappropriate use of restraints		A screen failure is indicated if one of the following occurs: 1. Use of restraint without an appropriate physician order. 2. PRN orders for restraint. 3. Lack of clinical justification or incorrect justification for restraint reflected in medical record. No documentation of behaviors which led to use of restraints or other less restrictive measures attempted prior to use of restraints. 4. Treatment planning does not address the need for restraint, that restraints were ordered more than once during hospitalization, and the requirements for terminating the restraint. 5. Restraint flow chart or notes demonstrate inadequate patient monitoring. (Adequate monitoring is defined on an individual need basis and may require one-to-one, constant monitoring, etc.) Monitoring must occur at least every 15 minutes. Offers to toilet must be made every two hours except when patient is asleep. Meals must be offered at regular times. 6. Lack of skilled psychiatric nursing summary written at least once every shift, assessing patient status. 7. Lack of physician progress note at a minimum of every 24 hours, or as in compliance with CMS, whichever is more stringent, assessing patient status and need for continued restraint. A screen failure is indicated if restraint placement results in inadequate circulation, improper body alignment, and/or signs of skin breakdown. Any serious injury(ies) during restraint process fails the screen.

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTE
7. Seclusion	None	Seclusion is defined as the involuntary confinement of a patient alone in a room, in which the patient is prevented from leaving, for any period of time.
a. Inappropriate use of seclusion		A screen failure is indicated if one of the following events occurs: 1. Use of seclusion without an appropriate physician order. 2. PRN orders for seclusion. 3. Lack of clinical justification or incorrect justification reflected in record. No documentation of behaviors which led to use of seclusion and other less restrictive measures attempted prior to seclusion. 4. Treatment planning does not address the need for seclusion, that seclusion was ordered more than once during hospitalization, and the requirements for terminating the seclusion. 5. Seclusion flow chart or notes demonstrate inadequate patient monitoring. (Adequate monitoring is defined on an individual need basis and may require one-to-one, constant monitoring.) Monitoring must occur at least every 15 minutes. Offers to toilet must be made every two hours except when patient is asleep. Meals must be offered at regular times. 6. Lack of skilled psychiatric nursing summary written at least once every shift, assessing patient status. 7. Lack of physician progress note at a minimum of every 24 hours, or as in compliance with CMS, whichever is more stringent, assessing patient status and need for continued seclusion.
b. Unsafe use of seclusion		Any serious injury(ies) during seclusion process fails the screen.
8. Electroconvulsive Therapy (ECT)	None	All children/adolescents (under the age of 18) receiving ECT must be reviewed by a physician reviewer. A screen failure is indicated if documentation regarding the ECT does not include all the following:
a. Inappropriate use of ECT		1. The nature and history of the clinical condition leading to the consideration of ETC. 2. The details of previous treatments, including therapeutic response and adverse reactions. 3. The reason for selecting ETC. 4. The signed consent form, with the signature of the patient and/or the relative or guardian when appropriate. 5. Specifics of the treatment (e.g., unilateral or bilateral electrode placement, dates of treatment, characteristics of the current drugs administered, etc.). 6. Pre- and post-monitoring of cognitive functioning (e.g., memory loss, confusion, etc.).

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTE
8. Electroconvulsive therapy (ECT) (continued) a. Inappropriate use of ECT (continued)		The screen is failed if ECT is performed for a diagnosis other than one in the following major categories: • Major Affective Disorder • Schizophrenia • Psychosis (other than psychotic organic brain syndrome)
b. Unsafe use of ECT		A screen failure is indicated if appropriate medical and laboratory work-up is not completed prior to initiation of treatment including, at a minimum, an ECG. Examination to determine the presence of any loose teeth/dentures should be documented. A screen failure is indicated if all of the following procedural details, essential to safe and acceptable ECT, are not present: 1. The direct supervision by a physician; 2. The administration of an anesthetic agent; 3. The administration of a muscle relaxant; and 4. Oxygen supplementation. A screen failure is indicated if there is no evidence of careful observation and monitoring of vital signs prior to, during, and after the treatment period. Documentation must address the adequacy of ventilation, the absence of cyanosis, and pulse rate, volume, and rhythmicity. Documentation must reflect the wakening of the patient which, at a minimum, includes the amount of time that the patient was drowsy, confused, and less than normally alert.
9. Inadequate discharge planning	Death Temporary transfer Left AMA	Discharge planning is appropriate for all patients. Discharge planning is a generic term which covers a range of care from the simple to the complex. The plan should be developed timely, as defined by the patient's needs, and must meet these needs at time of discharge. Documentation must address the following elements of the discharge plan: a. A needs assessment; b. Development of the plan; and c. Initiation of appropriate arrangements, including referral to appropriate resources when available, to ensure smooth transition to a post-hospital level of care.

ELEMENTS	EXCLUSIONS	EXPLANATORY NOTE
9. Inadequate discharge planning (continued)		The plan should reflect appropriate and timely follow-up arrangements and include a scheduled follow-up appointment. An explanation at the time of discharge should be documented if an appointment cannot be arranged. Patient refusal of suggested follow-up arrangements should be documented. Additional needed resources should be identified and appropriate teaching or transmission of pertinent information provided. A screen failure is indicated if a discharge plan is not documented. A discharge plan should be initiated upon admission for the child/adolescent population. A screen failure is indicated for failure to address patients with a high potential for near-term readmission [within 30 days] (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's capacity to maintain the treatment plan, or identified need for specialized outpatient milieu), when the medical record does not reflect efforts taken to address these issues to prevent further readmissions.
10. Deaths		All deaths must be reviewed by a physician reviewer.

ILLINOIS MEDICAL ASSISTANCE PROGRAM DETOXIFICATION CRITERIA

The following criteria should be applied during review of inpatient medical records with the principal diagnosis codes of 291, 292, 303, 304, and 305 and the diagnostic related groups of 433, 434, and 435.

SEVERITY OF ILLNESS (SI)

Admission to inpatient level of care requires meeting Severity of Illness specifications in at least one of the following three dimensions.

Dimension 1: Acute Intoxication or Withdrawal.

At risk of severe withdrawal as evidenced by at least **ONE** of the following:

- BAL > .3 gm % or equivalent (Breathalyzer)
- Seizures, delirium tremens, myoclonic contractions, or hyperpyrexia (above 101degrees Fahrenheit or 38.3 Celsius oral temperature)
- Overdose compromising mental status, cardiac functioning, or other vital signs
- Altered mental status with or without delirium as manifested by one of the following:
  - disorientation to self
  - alcoholic hallucinosis
  - toxic psychosis
  - violent or homicidal behavior
  - severe depression

OR at least **TWO** of the following:

- Documented Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) score $\geq$ 20
- BAL > .1 gm % with withdrawal
- Pulse >110 or BP 160/110 and documented CIWA-Ar score > 10
- History of seizures, hallucinations, myoclonic contraction, or delirium tremens when withdrawing

- Daily use of sedative hypnotics with alcohol for > 6 months or regular use of mind altering drug with distinct withdrawal syndrome
- Daily use of sedative hypnotics above the recommended therapeutic level for 4+ weeks (e.g., diazepam 40mg per day or conversion equivalent of other benzodiazepines)
- **Three** or more of the following signs/symptoms for opioid withdrawal, according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, 1994):
  - dysphoric mood
  - nausea and vomiting
  - muscle aches
  - lacrimation or rhinorrhea
  - papillary dilation, piloerection, or sweating
  - diarrhea
  - yawning
  - fever
  - insomnia
- Regular opioid use immediately prior to admission and prior discontinuation has resulted in significant withdrawal symptoms
- Strong likelihood of not completing outpatient detoxification as evidenced by failed outpatient and/or day treatment within last month with progressive psychosocial, occupational, or medical dysfunction

Dimension 2: Medical Conditions and Complications.

The following common co-existing medical conditions must also meet Medical Severity of Illness criteria.

- Common medical conditions that preclude treatment in a lesser care setting as evidenced by:
  - presence of medical problems requiring inpatient diagnosis and treatment
  - active gastrointestinal bleeding requiring control and replacement
  - cardiovascular disorders requiring cardiac monitoring
  - acute pancreatitis requiring parenteral treatment
  - liver disease with impending hepatic decompensation
  - multiple concurrent medical problems
- Disulfiram-alcohol reaction (Antabuse®) evidenced by:
  - severe nausea/vomiting requiring IV support OR
  - dysrhythmias requiring cardiac monitoring
- Life threatening symptomatology related to excessive use of alcohol or other drugs (e.g., ventilator dependent)
- Patient demonstrated other medical problems requiring 24 hour acute care
- Recent serious head trauma or loss of consciousness
- Need for concurrent medical management of psychiatric condition in an inpatient setting

Dimension 3: High Risk Conditions.

- Pregnancy concurrent with intoxicated or withdrawal state

INTENSITY OF SERVICE (IS)

On admission and with continued stay at this level of care require meeting the specifications in at least one of the following two dimensions **EACH DAY**. If stay for straight detoxification without medical complications exceeds three days, review coordinator referral to a physician reviewer is required.

Dimension 1: Acute Intoxication or Withdrawal.

Persistence of acute withdrawal symptoms and/or patients that need ongoing intense medication/management to minimize symptoms on a 24 hour basis as evidenced by:

- 24 hour skilled nursing care for observation with frequent (2-4 hours) vital signs and monitoring documented with appropriate medication adjustment **AND**
- Physician supervision as evidenced by daily progress notes, completed and signed, by the treating physician; **PLUS**
- Detoxification medications needed for management and fluctuation of symptoms on a daily basis, such as:
  - benzodiazepines
  - methadone
  - phenobarbital
  - clonidine

Dimension 2: Medical Condition and Complication.

Medical condition requiring continued treatment as well as treatment of addiction:

- Must meet Medical Intensity of Service criteria

DISCHARGE CRITERIA

Discharge from this level of care requires meeting the specifications in one of the following two dimensions:

Dimension 1: Acute Intoxication or Withdrawal.

The following **MUST** be met:

- Appropriate discharge plan/follow up arrangements as evidenced by:
  - A scheduled follow up appointment documented in the medical record at the time of discharge. An explanation at the time of discharge should be documented if an appointment can not be arranged. Patient refusal of suggested follow up arrangements should be documented, AND

  - A description of the type of follow up service as defined by the ASAM PPC-2 should be documented in the medical record. The following examples would be considered appropriate: residential halfway house, recovery center/home, intensive outpatient, group home, jail, shelter, partial hospitalization, or another hospital.

AND one of the following:

- Patient is assessed as not being intoxicated or in acute withdrawal (e.g. CIWA-Ar <10 in two measurements eight hours apart or two narcotic withdrawal scales < 2 measured eight hours apart) **AND/OR** the patient's medication(s) can be safely administered in another setting **PLUS** does not meet any of the continued stay criteria
- Patient agrees to enter continuing addictions and/or psychiatric treatment
- Patient refuses any continued treatment and does not meet any continued stay criteria

Dimension 2: Medical Conditions and Complications.

The following **MUST** be met:

- Appropriate discharge plan/follow-up arrangements as evidenced by:

  - A scheduled follow up appointment documented in the medical record at the time of discharge. An explanation at the time of discharge should be documented if an appointment can not be arranged. Patient refusal of suggested follow up arrangements should be documented, AND

- A description of the type of follow up service as defined by the ASAM PPC-2 should be documented in the medical record. The following examples would be considered appropriate: residential halfway house, recovery center/home, intensive outpatient, group home, jail, shelter, partial hospitalization, or another hospital.

AND one of the following:

- Patient's medical condition has improved or stabilized so that acute care services are no longer necessary **AND** the patient no longer meets continued stay criteria
- Medical condition has arisen or condition that requires treatment in another setting (NOTE: RC would need to continue review (length of stay) using Medical Intensity of Service criteria)

(Reserved)

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE (CIWA-Ar)

Many quantification instruments have been developed for monitoring alcohol withdrawal (Guthrie, 1989; Sullivan et al, 1989; Sellers and Naranjo, 1983). No single instrument is significantly superior to the others. What is clear is that there are significant clinical advantages to quantifying the alcohol withdrawal syndrome. Quantification is key to preventing excess morbidity and mortality in a group of patients who are at risk for alcohol withdrawal. Such instruments help clinical personnel recognize the process of withdrawal before it progresses to more advanced stages, such as *delirium tremens*. By intervening with appropriate pharmacotherapy in those patients who require it, while sparing the majority of patients whose syndromes do not progress to that point, the clinician can prevent over- and under-treatment of the alcohol withdrawal syndrome. Finally, by quantifying and monitoring the withdrawal process, the treatment regimen can be modified as needed.

The best known and most extensively studied scale is the Clinical Institute Withdrawal Assessment - Alcohol (CIWA-A) and a shortened version, the CIWA-A revised (CIWA-Ar). This scale has well-documented reliability, reproducibility and validity, based on comparison to ratings by expert clinicians (Knott, et al, 1981; Wiehl, et al 1994; Sullivan, et al, 1989). From 30 signs and symptoms, the scale has been carefully refined to a list of 10 signs and symptoms in the CIWA-Ar (Wiehl, et al, 1994). It is thus easy to use and has been shown to be feasible to use in a variety of clinical settings, including detoxification units (Naranjo, et al, 1983; Hoey, et al, 1994), psychiatry units (Heinala, et al, 1990), and general medical/surgical wards (Young, et al, 1987; Katta, 1991). The CIWA-Ar has added usefulness because high scores, in addition to indicating severe withdrawal, are also predictive of the development of seizures and delirium (Naranjo, et al, 1987).

The CIWA-Ar scale can measure 10 symptoms. Scores of less than 8 to 10 indicate minimal to mild withdrawal. Scores of 8 to 15 indicate moderate withdrawal (marked autonomic arousal); and scores of 15 or more indicate severe withdrawal (impending *delirium tremens*). The assessment requires 2 minutes to perform (Sullivan, et al, 1989).

The CIWA-Ar categories, with the range of scores in each category, are as follows:

Agitation	(0-7)
Anxiety	(0-7)
Auditory disturbances	(0-7)
Clouding of Sensorium	(0-4)
Headache	(0-7)
Nausea/Vomiting	(0-7)
Paroxysmal Sweats	(0-7)
Tactile disturbances	(0-7)
Tremor	(0-7)
Visual disturbances	(0-7)

The instrument also has been adapted for benzodiazepine withdrawal assessment (Clinical Institute Withdrawal Assessment - Benzodiazepine).

A study of the revised version of the CIWA predicted that those with a score of >15 were at increased risk for severe alcohol withdrawal (RR 3.72; 95% confidence interval 2.85-4.85); the higher the score, the greater the risk. Some patients (6.4%) still suffered complications, despite low scores, if left untreated (Foy, et al, 1988).

References

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Addiction Research Foundation
Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar)

Patient: Date: Time:	Pulse or heart rate, taken for 1 minute: Blood pressure:
NAUSEA AND VOMITING: Ask, "Do you feel sick to your stomach? Have you vomited?" Observation: 0 No nausea and no vomiting 1 Mild nausea with no vomiting 2 3 4 Intermittent nausea with dry heaves 5 6 7 Constant nausea, frequent dry heaves and vomiting	TACTILE DISTURBANCES: Ask, "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling under your skin?" Observation: 0 None 1 Very mild itching, pins and needles, burning or numbness 2 Mild itching, pins and needles, burning or numbness 3 Moderate itching, pins and needles, burning or numbness 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations
TREMOR: Arms extended and fingers spread apart. Observation: 0 No tremor 1 Not visible but can be felt fingertip to fingertip 2 3 4 Moderate, with patient's arm extended 5 6 7 Severe, even with arms not extended	AUDITORY DISTURBANCES: Ask, "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation: 0 Not present 1 Very mild harshness or ability to frighten 2 Mild harshness or ability to frighten 3 Moderate harshness or ability to frighten 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations
PAROXYSMAL SWEATS: Observation: 0 No sweat visible 1 2 3 4 Beads of sweat obvious on forehead 5 6 7 Drenching sweats	VISUAL DISTURBANCES: Ask, "Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation: 0 Not present 1 Very mild sensitivity 2 Mild sensitivity 3 Moderate sensitivity 4 Moderately severe hallucinations 5 Severe hallucinations 6 Extremely severe hallucinations 7 Continuous hallucinations

Appendix H-6 (26b)

Addiction Research Foundation
Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar)
(continued)

ANXIETY: Ask, "Do you feel nervous?" Observation: 0 No anxiety, at ease 1 Mildly anxious 2 3 4 Moderately anxious, or guarded, so anxiety is inferred 5 6 7 Equivalent to acute panic states, as seen in severe delirium or acute schizophrenic reactions.	HEADACHE, FULLNESS IN HEAD: Ask, "Does your head feel different? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness. Otherwise, rate severity: 0 Not present 1 Very mild 2 Mild 3 Moderate 4 Moderately severe 5 Severe 6 Very severe 7 Extremely severe
AGITATION: Observation: 0 Normal activity 1 Somewhat more than normal activity 2 3 4 Moderately fidgety and restless 5 6 7 Paces back and forth during most of the interview, or constantly thrashes about	ORIENTATION AND CLOUDING OF SENSORIUM: Ask, "What day is this? Where are you? Who am I?" Observation: 0 Oriented and can do serial additions 1 Cannot do serial additions or is uncertain about date 2 Disoriented for date by no more than 2 calendar days 3 Disoriented for date by more than 2 calendar days 4 Disoriented for place and/or person
SCORE:_____(maximum possible score = 67)	Note: This scale is not copyrighted and may be used freely.